Gagandeep Munday
H & P: Family Medicine Rotation
05/19/2021

Identifying Data:

Full Name: FS
Address: Queens, NY
Age: 43
Date & Time: May 19, 2021 @ 4:00pm
Location: South Shore Family Medical

Religion: None
Reliability: Reliable
Source of Information: Self
Source of Referral: Self
Mode of Transport: Ambulatory

Chief Complaint: "My chest has been hurting for 2 hours"

History of Present Illness:
43 y/o AA M PMH hyperlipidemia and vitamin D deficiency c/o central chest pain for 2 hours. Describes it as a "crushing in the middle" 8/10 chest pain. Endorses radiation of pain up to right side of neck. States that he had a similar episode while resting last night with 5/10 chest pain, wanted to go to the ER but instead tried to "sleep it off". Current episode started 2 hours ago as patient was sitting on his recliner at home. States that pain in chest has been consistent since onset. Denies taking any medication for his symptoms. Denies diaphoresis, syncope, palpitations, leg pain/ swelling, SOB, headache, dizziness, nausea, vomiting, recent cough/cold, recent trauma, or illicit drug use.

Past Medical History:
Present illness: Hyperlipidemia, Vit D Deficiency
Past illness: none
Hospitalizations: none
Immunizations: flu vaccine yearly, all others Up to Date

Past Surgical History:
Denies injuries, past surgeries and transfusions.

Medications:
Ergocalciferol 5000 Unit Capsule, 1 orally weekly
Denies taking any other medications or herbal supplements.

Allergies:
Denies any known drug allergies

Family History:
Mother 74, alive, hx of type 2 diabetes, **hx of MI at age 50**
Father 78, alive, hx Hyperlipidemia, **hx of stroke at age 62**

Social History:
Habits: FS denies ever smoking cigarettes. Endorses drinking one beer a day. Denies any past or present illicit drug use.

Travel: no recent travel
Marital History: single
Sexual History: sexually active with women. Denies any history of STD.
Occupation: currently not working due to the pandemic
Home: Pt lives an apartment building on the 11th floor. Denies any problems at home.
Diet: Reports that he consumes a balanced diet, lots of meats, rice and vegetables.
Sleep: Reports that he usually gets 9 hours of sleep every night
Exercise: Reports that he does not exercise at all, occasionally goes for a walk.
Safety: Pt admits to wearing a seat belt

Review of Systems:
General- Denies fever, chills, night sweats, fatigue, weakness, loss of appetite, recent weight gain or loss
Head- Denies headache, vertigo, unconsciousness,
Eyes- Denies vision changes
Pulmonary- Denies dyspnea, SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, PND
Cardiovascular- **Chest pain.** Denies HTN, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, known heart murmur
Gastrointestinal: Denies change in appetite, nausea, vomiting, dysphagia, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, blood in stool,
Genitourinary: Denies urinary frequency, incontinence, dysuria, nocturia, urgency, oliguria, ' polyuria,
Peripheral Vascular- Denies intermittent claudication, coldness, trophic changes, varicose veins, peripheral edema, color changes
Nervous System: Denies seizures, dizziness, loss consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory, weakness

Physical
Vital Signs:
Blood Pressure: 126/79 mmhg
Heart Rate: 86 bpm
Respiration Rate: 16 breaths/min
Temperature: 98.3 F

O_2 Sat: 98% room air
Height: 71 inches
Weight: 208 lbs
BMI: 29

General Appearance: 43 yo male A/O x 3. Pt has large build and good posture, well dressed and groomed. **Appears uncomfortable**.

Skin: Warm and moist/dry, good turgor, anicteric, no lesions, no rashes, no scars, no tattoos.

Nails: No clubbing, no discoloration, capillary refill <2 sec throughout.

Hair: Average quantity and distribution, no signs of alopecia, seborrhea, or lice.

Eyes: symmetrical OU, no evidence of strabismus or ptosis noted, sclera (white/ red), conjunctiva and cornea clear. Visual fields intact, OU, PERRLA, EOMI full with no nystagmus.

Head: normocephalic, atraumatic, nontender to palpation throughout, no signs of alopecia, seborrhea, or lice. Nontender to palpation throughout

Chest: Symmetrical, no deformities, no signs of trauma. Respiration unlabored/ no parodoxic respiration or use of accessory muscles noted. Lat AP diameter 2:1. Non-tender to palpation.

Lungs: Clear to auscultation bilaterally, no rales/rhonchi/wheezes, no egophony, no tactile fremitus, normal percussion.

Cardiovascular: Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

Peripheral Vascular: Extremities are normal in color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted.

Neurological: Alert and oriented to person, place, and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted.

Labs/procedures:
EKG: ST elevations in II, III, and aVF, Regular rhythm 73 bpm, Normal PR, narrow QRS, normal QT, No axis deviation, No BBB, no hypertrophy

Differential based off Chief Complaint:

1. Myocardial Infarction/ACS
2. Aortic dissection
3. Pulmonary Embolism
4. Pneumothorax
5. Previous MI
6. Hyperkalemia

Assessment
35 y/o M, PMH hyperlipidemia and vitamin D deficiency c/o central crushing chest pain for the past 2 hours. Also reports having similar chest pain last night but decided not to go to the ED at that time. During both episodes patient reports that he was at rest. EKG showed ST elevations in lead II, III, avF. Likely inferior MI 2/2 occluded RCA.
Problem List:

1. Chest pain

Plan:
PT was given aspirin 325mg and sent to the Emergency Room via EMS for full cardiac workup

- Consider chest x-ray, repeat ECG, and echo
- Consider labs CBC, CMP, ESR, CRP, Troponin, CK-MB, PT/PTT
- Admission with telemonitoring and consider thrombolytics since onset was 2 hours ago